A Plan of Action for Improving the Oral Health Status of Michigan Residents

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Introduction

"I can see clearly now the rain is gone. I can see all obstacles in my way."
~ from the song *I Can See Clearly Now* by Johnny Nash

This simple phrase summarizes the status of oral health in Michigan. While we know there are obstacles, we can see them and, as a result, plan for how to overcome them. The recent creation and continuous expansion of the **Michigan Oral Health Coalition** has brought with it momentum to move oral health to the forefront of policy discussions. The connection between oral health and systemic health is beginning to be recognized by not only policymakers but also the public at large. The coalition, as well as multiple trade associations and advocates, has identified that oral health is integral to primary health care and has been actively communicating this statewide. As a statewide community, we now know where we are going and are preparing for how to get there.

The Michigan Department of Community Health (MDCH) recognized the need for Michigan to develop a coordinated effort around improving the oral health status of residents and submitted a proposal to the Centers for Disease Control and Prevention (CDC) to build up the oral health infrastructure in Michigan and develop a state oral health plan. Michigan is now in the second year of this infrastructure project.

The Michigan Oral Health Coalition kicked off on December 11, 2003, with a full membership meeting. At this meeting, participants were welcomed by Janet Olszewski, Director of the Michigan Department of Community Health. Director Olszewski stressed to the participants the important role of the coalition and the commitment of MDCH to adopt the five-year plan of action developed by the Oral Health Coalition. At the kick off participants also identified a mission, outlined important issues, and described oral health assets in Michigan.

The actions outlined in this paper are designed to improve the oral health status of Michigan's residents. Such a challenging task would not be possible without the work of many motivated organizations and individuals. This paper represents the work of an interagency coalition known as the Michigan Oral Health Coalition. **Members of the coalition include:**

- *Advantage Health Centers* / Detroit
- *Alcona Health Center* / Lincoln
- *Baker College* / Port Huron
- *Baldwin Family Health Care* / Baldwin
- *Blue Cross Blue Shield of Michigan* / Southfield
- *Branch, Hillsdale,* and *St. Joseph County Health Department* / Coldwater
- *Calhoun County Health Department* / Battle Creek
- *Capital Area Community Services, Inc.* / Lansing
- *Capital Area Health Alliance* / Lansing
- *Center for Family Health* / Jackson
- *Cherry Street Health Services* / Grand Rapids
- *Children's Hospital of Michigan* / Detroit
- *Delta Dental Plan of Michigan* / Lansing
- *Dental Clinics North* / Charlevoix
- *Detroit Community Health Connection* / Detroit
- *Detroit Department of Health & Wellness Promotion* / Detroit

- *Family Health Center of Battle Creek* / Battle Creek
- *Family Independence Agency* / Lansing
- *Hackley Community Care Center* / Muskegon Heights
- *Hackley Hospital* / Muskegon
- *Hamilton Community Health Network* / Flint
- *Head Start-State Collaborative Program* / Lansing
- *Health Delivery, Inc.* / Saginaw
- *Henry Ford Health System, School Health Initiative* / Detroit
- *Hillsdale County Human Services Network* / Hillsdale
- *Ingham County Health Department* / Lansing
- *Ingham Oral Health Coalition* / Lansing
- *Intercare Community Health Network* / Bangor
- *InterTribal Council* / Sault Ste. Marie
- *Ionia County Health Department* / Ionia
- *Kalamazoo County Dental Clinic* / Kalamazoo
- *Lansing Community College Dental Hygienist Program* / Lansing
- *Lifeways* / Jackson
- *Marquette County Health Department* / Marquette
- *Medical Services Administration* / Lansing
- *Michigan Academy of Pediatric Dentistry* / Flint
- *Michigan Council for Maternal and Child Health* / Lansing
- *Michigan Dental Association* / Lansing
- *Michigan Dental Assistants Association* / Lansing
- *Michigan Dental Hygienists Association* / East Lansing
- *Michigan Department of Community Health* / Lansing
- *Michigan Department of Education* / Lansing
- *Michigan Department of Environmental Quality* / Lansing
- *Michigan Department of Environmental Quality-Water Division* / Lansing
- *Michigan Family Resources, Inc.* / Walker
- *Michigan Health & Hospital Association* / Lansing
- *Michigan Health Council* / Okemos
- *Michigan Primary Care Association* / Okemos
- *Michigan Public Health Institute* / Okemos
- *Michigan Spit Tobacco Education Program* / Lansing
- *Mid-Michigan District Health Department* / Stanton
- *Mobile Dentists/Children's Dental Health Foundation* / Farmington Hills
- *Monroe County Health Department* / Monroe
- *Mott Children's Health Center* / Flint
- *Muskegon Community Health Project* / Muskegon
- *Muskegon County Health Department* / Muskegon
- *Muskegon Family Care* / Muskegon
- *Northwest Michigan Community Health Agency* / Traverse City
- *Northwest Michigan Health Services, Inc.* / Traverse City
- *Oakland/Livingston Human Service Agency, Child Development Division* / Pontiac
- *Omni Oral Pharmaceuticals* / Kentwood
- *Ottawa County Health Department* / Holland
- *Public Sector Consultants* / Lansing
- *Saginaw County Department of Public Health* / Saginaw
- *Sault Tribe of Chippewa Indians* / Sault Ste. Marie

- *School-Community Health Alliance of Michigan* / Okemos
- *St. Clair County Health Department* / Port Huron
- *Sterling Area Health Center* / Sterling
- *Telamon Corporation* / Lansing
- *Tri-County Dental Health Council* / Southfield
- *University of Detroit Mercy School of Dentistry* / Detroit
- *University of Michigan Health System* / Ann Arbor
- *University of Michigan School of Dentistry* / Ann Arbor
- *University of Michigan School of Public Health* / Ann Arbor
- *Upper Peninsula Association of Rural Health Services* / Marquette
- *Van Buren/Cass County Health Department* / Hartford
- *Washtenaw Children's Dental Clinic* / Ann Arbor
- *Wayne County Health Department* / Detroit
- *Wolverine Dental Society* / Detroit

Mission

To improve oral health in Michigan by focusing on prevention, health promotion, surveillance, access and the link between oral health and total health.

Key oral health assets and issues were identified at the kick off meeting of the Michigan Oral Health Coalition and were identified as follows:

Assets

- CDC grant for prevention
- A good supply of dentists, dental auxiliary, physicians, and nurses (albeit maldistributed)
- Major universities with expertise to work with community partners
- Fluoridated water in many communities
- Grassroots coalitions in local communities
- Safety-net dental programs, including those at Federally Qualified Health Centers, local health departments, and school-based health centers
- Protection of oral health services for children through Early Periodic Screening, Diagnosis, and Testing
- Education and business partnerships
- Health education in schools - Michigan Model (K-12) includes oral health
- Governor Granholm and her administration interested in oral health
- Media interested in health issues
- Strong third-party payor structure
- Health professional students
- Passionate leaders and vision

Key Issues

- Lack of providers willing to serve low-income people and those with special needs
- Lack of a State Oral Health Officer
- Lack of public awareness of importance of oral health
- Lack of utilization of all dental professionals
- Lack of pediatric dental resources
- Provider maldistribution
- Scope of practice limitations
- Lack of statewide data
- Lack of affordable services for uninsured
- Lack of Medicaid adult dental coverage
- Lack of oral health funding in general
- Lack of public/private funding for prevention strategies
- Insufficient payment rates

Participants then voted, as a way to guide deliberations, for those issues they felt were the most significant facing oral health in Michigan. The issues were divided among key topics and **workgroups formed**: Data, Prevention, Education and Awareness, Funding, Leadership, and Workforce. The workgroups were asked to begin by addressing those issues of highest concern. Workgroup chairs were nominated and meeting participants identified workgroups in which they wished to participate. Michigan Primary Care Association (MPCA) staff provided support to all workgroups in order to coordinate efforts between groups and provide documentation of their activities.

After the kick-off meeting, a **Steering Committee** of key stakeholders representing broad oral health interests and backgrounds was selected to guide the work of the coalition. The 10 member Steering Committee was comprised of the workgroup chairs and other leaders within the oral health community. The committee met throughout the development of the plan to review preliminary work plans and meeting summaries from the workgroups to avoid overlap among workgroups and ensure that all grant objectives were being met. As the Steering Committee noted areas that could be strengthened, additional members were asked to join based on their expertise.

The Oral Health Coalition has nearly 160 members who are involved in various workgroups. Five workgroups met on a regular basis and were led by volunteer workgroup chairs. Workgroup sizes ranged between 10 and 22 members. The meetings focused on the development of goals and objectives related to their specific area of focus. After four months of meetings, it was determined that the objectives of the **Leadership Workgroup** could easily be folded into the activities of other workgroups and, as a result, discontinued. The final work plan includes the goals and objectives outlined by the remaining four workgroups.

In May and November 2004, the entire Michigan Oral Health Coalition reconvened to review each of the workgroups' draft work plans and oral health surveillance findings. Membership then worked together to establish the next steps for the coalition. The work plans were then incorporated into the **Plan of Action** and presented to the Steering Committee, the workgroups, and the full coalition for review and approval. After the coalition approved the draft plan, it was presented at five community meetings across the state in order to gain feedback. The forums occurred in Grand Rapids, Detroit, Gaylord, Saginaw, and Marquette via video conference. Approximately 100 participants attended a community meeting to give feedback on the plan. These comments were summarized in a report prepared by Public Sector Consultants and presented to the coalition for review. Workgroups adapted the plan as a result of forum comments. These changes were presented to the Steering Committee and then the full coalition. The plan was submitted for approval by the Michigan Department of Community Health in May 2005. In August 2005, the Plan was officially approved by the Director of MDCH, Janet Olszewski.

Strategies to Identify Best Practices

Workgroups will continue to convene as necessary to implement each of the activities outlined in the Plan of Action. They will also continue to identify **best practices** that can be replicated in Michigan and share practices that may be helpful to other states through continued collaboration with the Association of State and Territorial Dental Directors (ASTDD) and the CDC. Workgroups have identified best practices that they will implement in their work plans. For example, the Workforce work plan has proposed to research approaches used by other states to address access issues with the current workforce.

Implementation Strategies, Leveraging of Resources, Partnerships, and Plan Maintenance

The Michigan Oral Health Coalition is fortunate enough to have nearly 160 individual partners with a broad range of experience who are eager to begin implementation of the plan. Responsible individuals or organizations have been identified in the plan as the lead to ensure that action steps are accomplished. Workgroups will continue to meet as necessary to monitor their progress and if appropriate identify and incorporate new research initiatives. The MDCH Oral Health Program Coordinator will act as a liaison between the coalition and MDCH. Progress on the implementation of the plan will be reported at the annual conference and coalition meeting hosted by MDCH and MPCA.

Many of the coalition partners have **committed local resources** to implement various components of the action plan. For example, the Michigan Dental Association has volunteered to spearhead the statewide oral health campaign each February. Many other activities can be accomplished utilizing existing resources. The Oral Health Coalition will continue to examine resources at the state and local level that may be leveraged in order to complete the outlined objectives.

Healthy People 2010 Objectives & Evaluation Strategies for Monitoring the Outcomes and Impacts of Plan Implementation

An **evaluation committee** convened by the Michigan Department of Community Health will periodically evaluate the effectiveness of the coalition. The surveillance provided by the Data Workgroup and the monitoring mechanisms identified in the action plan will serve as key evaluation tools in monitoring the effectiveness of coalition activities. The coalition Steering Committee will serve as members of the evaluation committee. The Oral Health Coalition Workgroups will work with MDCH to provide continuous reporting on the oral health status of Michigan residents and present this information as well as reporting progress on the impact of prevention interventions annually during the annual Oral Health Coalition meeting each June. The surveillance plan includes each of the *Healthy People 2010* Oral Health Objectives, which will be continuously monitored for improvement. Status on meeting each of the *Healthy People 2010* objectives will be provided annually the Michigan Department of Community Health evaluation committee.

• Oral Health & Systemic Health •

One of the primary areas of focus of the Michigan Oral Health Coalition is recognition of the connection between systemic health and oral health. Inattention to oral health has important implications for our ability to reach current and future health outcome goals. Poor oral health has effects on pre-term births/low birth weight babies, diabetes control, heart disease, and respiratory disease.

National Institute of Health funded studies estimate that as many as 18% of the 250,000 **premature babies** born weighing less than 5.5 pounds in the United States each year are due to periodontal infection (NIDCR, 2004). Pregnant women with periodontal disease may be seven times more likely to have a baby who is born too early or too small (AAP, 2004).

Recent studies point to an increased risk of **heart disease and stroke** in people with periodontal disease. The risk increases with the severity of infection. Heart disease is the leading cause of death in Michigan (MDCH, 2003).

Numerous studies have shown the impact periodontal disease can have on **diabetes**. People with diabetes are twice as likely to have periodontal disease (ADHA, 2003). Periodontal disease makes it more difficult to control blood sugar levels, and badly managed blood sugar levels can make periodontal problems worse. The Michigan BRFSS found that 41.8% of individuals with diabetes had lost six or more teeth in 2002 compared to 15.2% for those without diabetes (MDCH BRFSS, 2003).
Many systemic diseases have oral manifestations and can inform clinicians of the need for further evaluation. The oral cavity can also be adversely affected by many pharmaceuticals and other therapies commonly used in treating systemic conditions. Finally, individuals such as immunocompromised and hospitalized patients are at greater risk for morbidity due to oral infections.

Oral Health Status of Michigan Residents

Oral Health Infrastructure

The Michigan Department of Community Health recognized the need for Michigan to develop a coordinated effort around improving the oral health status of residents and submitted a proposal to the Centers for Disease Control and Prevention. Michigan is now in the second year of this infrastructure project. The previous two-year planning grant focused on the development of a baseline oral health assessment and assessing Michigan's current oral health surveillance tools. Another area of focus during the first two years was providing training, consultation, and technical assistance to communities on conducting an oral health capacity/staffing assessment, conducting a validation survey of services for children less than 20 years of age, and utilizing data in program planning.

The **first year** of the current five-year (Fiscal Year '04 to Fiscal Year '08) proposal focused on the formation of a coalition. The coalition is responsible for the development of a five-year plan to improve oral health and compilation and analysis of data available to implement a statewide oral health surveillance system. These activities began in July 2003. A part-time oral health epidemiologist was hired at MDCH to begin working on the surveillance system and MDCH contracted with Michigan Primary Care Association (MPCA) to develop and facilitate the activities of the Oral Health Coalition.

Michigan had been without an Oral Health Program Coordinator at the Michigan Department of Community Health for two years, until September 2004. The lack of a statewide coordinator to spearhead statewide efforts had left a considerable gap in the state. An oral health coordinator was hired in September 2004, who has aided in the coordination of services in the state.

In 1991, the Michigan Department of Community Health, with the assistance of an interagency workgroup, developed the **Michigan Oral Data (MOD) System** as a tool to provide a dental disease

profile of the population served in the participating publicly funded dental clinics. The system involves the collection of caries, untreated decay, and several other oral health indicators. Currently 11 dental clinics in Michigan collect oral health data using this system. The MOD System is not population based or statewide; but, data from the system can provide some insight on the status of oral disease and may be a useful component of the statewide oral health surveillance system. Efforts continue in order to expand the number of clinics in Michigan who collect oral health data using the MOD system.

In the future, the Michigan Oral Health Coalition is examining the use of an additional source of oral health data. The **Basic Screening Survey (BSS)** is a statewide and population based oral data collection tool. The BSS is a standardized set of forms developed to collect information on the observed oral health of participants of all ages. The survey notes the presence of untreated decay and the urgency for treatment of all ages and edentulism in adults.

There is concern that the oral health infrastructure for underserved individuals in Michigan and the health status of residents is at risk. Oral health services for adults on Medicaid, beyond emergency care, were eliminated as of October 2003. With the elimination of the benefit more than 600,000 adults in Michigan lost access to oral health care. This benefit elimination has forced dental clinics to reduce hours and caused at least one clinic to cease operation.

Description of Priority Populations, Burden of Disease & Caries

Dental caries (tooth decay) have been considered the single most common chronic **childhood disease**. According to the MOD System findings, approximately one in six underserved children had evidence of early childhood caries. Among 6- to 12-year-old children, 46.3% had caries experience in their permanent teeth and 30.8% had untreated permanent tooth decay. An average of 2.9 permanent teeth had decay among children with caries experience. The rate of caries experience in permanent teeth is dramatically higher among underserved adolescents at 82%, with 54.6% having untreated decay (MDCH, 2004). It is difficult to make direct comparisons to national caries data for these age breakdowns; however, national numbers can be found in Figure 1.

The MOD System also indicated poor oral health status for **underserved adults**. Two-thirds of underserved adults in Michigan aged 20-64 had untreated permanent tooth decay and 55.6% had lost at least one tooth due to caries experience or periodontal disease (MDCH, 2004). In comparison, the CDC estimates that nationally approximately one-third of poor adults 18 and over have untreated decay in a permanent tooth (CDC, 2004). The Michigan system also found that nearly one in six of the adults had root caries experience.

The coalition proposes ongoing surveillance of caries experience in both children and adults. Other activities geared at reducing the incidence of caries include providing education on oral health throughout the lifespan, supporting efforts of MDCH to implement a school-rinse program and school-based sealant program, and improving access to preventive care for underserved populations.

Early Childhood Caries (ECC)

The **2003 Michigan Child Dental Coverage Validation Survey** reported that among all children under age four, 29.3% had been put to bed at least occasionally with a bottle of juice, formula, milk, or other liquid besides water (Eklund, 2003). The validation survey found there were significant differences based on the age and ethnicity of the respondent. Respondents under age 30 were much more likely to report this having been done at least occasionally (41.4%) compared to those respondents 30-39 years of

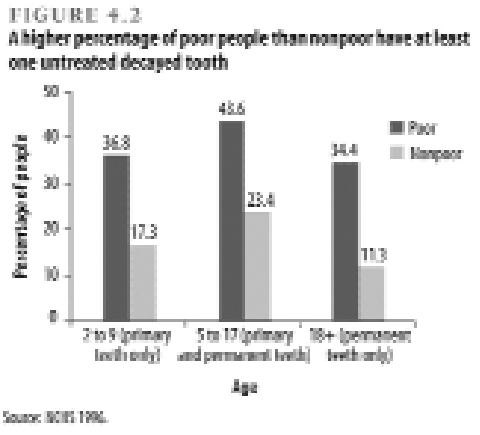
age (18.9%). Hispanic respondents also reported a higher rate than non Hispanics, 76.5% compared to 27.3%, of occasionally putting children under age four to bed with a bottle of liquid other than water.

Disparities

One of the greatest disparities in oral health is by **income**. According to the U.S. Surgeon General's Report, *A National Call to Action to Promote Oral Health (2003)*, poor children suffer twice as many dental caries as their more affluent peers and their decay is more likely to be untreated.

Figure 1 to the right from *Oral Health in America: A Report of the Surgeon General* demonstrates oral health disparity by income in the United States.

Figure 1.



The **2002 Michigan Behavioral Risk Factor Surveillance System (BRFSS)** (MDCH BRFSS, 2003) provides additional estimates regarding oral health status and behaviors of Michigan residents. The BRFSS estimates prevalence of certain behaviors, conditions, and practices in Michigan adults. These estimates are based on data collected from a random-digit dial telephone survey of Michigan households. This system is designed to be statewide and population based, and in comparison, is much broader than the MOD system utilizing information from 11 clinics. The 2002 Michigan BRFSS demonstrated that 47.6% of individuals with household incomes below $20,000 had not visited a dentist in the previous year. In contrast, only 15.9% of individuals with household incomes between $50,000 and $74,999 had not visited the dentist within the previous year.

Closely connected to income, level of **educational attainment** similarly impacts the status of oral health care in Michigan. According to the 2002 BRFSS, among those individuals with less than a high school education only 51.2% received dental care in the previous year, compared to 86.4% for college graduates.

Racial disparities are also evident in oral health status. According to the 2002 Michigan BRFSS, 35.1% of individuals who had identified themselves in the survey as black had not visited a dentist in the previous year, compared to 21.4% for individuals who had identified themselves as white. Michigan also experiences higher rates of oral cancer incidence and mortality among African-Americans.

Oral Cancer, Periodontal Disease, and Infection Control

Oral Cancer

According to the **University of Michigan, School of Dentistry's 2003 report** *Epidemiology of Oral Cancer in Michigan*, while the oral cancer mortality rate in Michigan is slowly decreasing and is lower than the national average, certain populations are disproportionately impacted. The report indicated the Michigan oral cancer mortality rate from 1990-1999 was 2.9 per 100,000 persons compared to the national rate of 3.2 per 100,000 persons.

The report further explained that Michigan males had much higher oral cancer incidence and mortality rates than females during the 1990s. African-American males had the highest oral cancer incidence and

mortality rates among all races and gender groups. The incidence rate of oral cancer in African-American males of 25 per 100,000 individuals was 1.5 times higher than the rates of the white males and 3.6 times higher than the rates of the African-American females. The attached Plan of Action outlines activities aimed at improving the oral cancer mortality rate and the disparities that exist.

The Data Workgroup and the MDCH Oral Health Epidemiologist will investigate options to measure periodontal disease in Michigan. Measures to improve oral health status and reduce periodontal disease are identified throughout the Plan of Action, including education on the importance of oral heath care and improving access to care for un-served populations.

All individuals involved in clinical activities related to the work of the coalition will be educated on the CDC's Guidelines for Infection Control in Dental Health-Care Settings (2003). Information on statewide trainings on infection control in the dental setting will be widely distributed to coalition partners. MPCA will also propose hosting a session on Infection Control at the annual Michigan Oral Health Conference in which continuing education credits are made available.

Diabetes

Studies have shown several relationships between oral health and diabetes. In Michigan, the 2002 BRFSS found that persons with diabetes were much more likely to have lost six or more teeth than those without diabetes (MDCH Diabetes 2004). Nearly forty-two percent of those with diabetes lost six or more teeth compared to just over 15% for those without the disease.

• Access to Care •

While certain populations in Michigan are able to access dental care easily in their community, there are many for whom access to dental care is extremely limited. The oral health disparities in the United States due to these access barriers are vast. The **2003 Michigan Child Dental Coverage Validation Survey** reported that for children three years of age and older, 83.8% of them had seen a dentist within the past 12 months. The survey demonstrated that those without dental insurance are twice as likely to have never visited a dentist as were those with insurance. Of the children without dental insurance, 11.2% had never visited the dentist compared to 5.2% for those with dental insurance (Eklund, 2003).

Michigan established a **State Children's Health Insurance Program (SCHIP), MIChild**, which offers insurance for children who are uninsured and not eligible for Medicaid. The MIChild dental program has had great success in provider participation and in the number of children utilizing dental care. The increased provider participation has been attributed to increased reimbursement levels and decreased administrative burden.

Michigan also has a dental demonstration project in 37 of Michigan's 83 counties called **Healthy Kids Dental**. The program has moved the children who were in the traditional Medicaid dental program into this state-private dental partnership. This was accomplished by purchasing the use of a private dental health plan that results in increased Medicaid reimbursement levels and reduced administrative

difficulties. It has proven to be effective in increasing the number of children who receive dental care in the rural counties where it has been implemented by increasing the number of providers willing to care for the patients.

Thirty percent of Michigan's children were enrolled in **Medicaid** in 2002. Only 23% of Medicaid enrolled children aged 0-19 received a dental visit during that same time period. Of all Michigan children, including those on Medicaid, 51% had a dental visit during that same year. Figure 2 depicts the proportion of Medicaid enrolled children who had at least one dental visit in 2002. Figure 3 depicts the proportion of all Michigan children who had at least one dental visit in 2002 (Eklund, 2003).

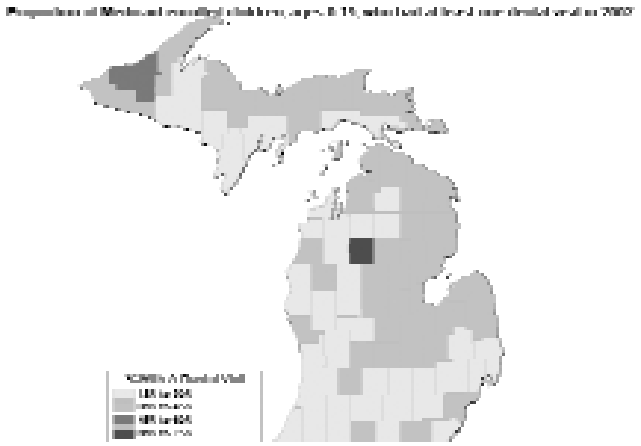


Figure 2.

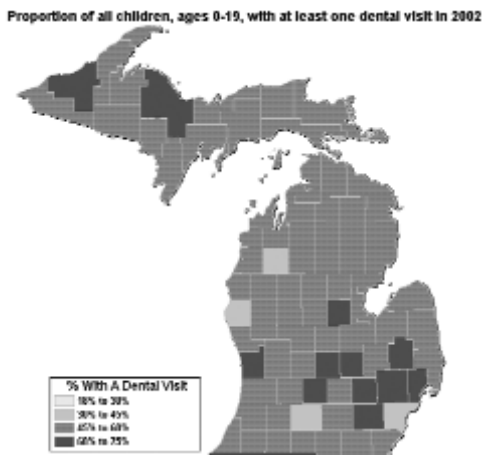


Figure 3.

Despite efforts of a few existing dental programs for persons with special needs (e.g. those who are medically compromised or who are mentally impaired), access barriers continue to plague these individuals. One issue is the availability of medical facilities for the provision of dental services under sedation or with medical support. Provider training programs also continue to be limited, which in turn has restricted access in many parts of the state.

Strategies to Address Oral Health Promotion Across the Lifespan

The Michigan Oral Health Coalition is focused on improving oral health throughout the lifespan beginning with proper prenatal oral health care and continuing through care in nursing homes and at home health facilities. Comprehensive oral health education resources will be developed for all ages and non-dental health care providers will be provided with information on the importance of oral health. The coalition will continue to build networks throughout the state to improve education on the importance of oral health for individuals throughout the lifespan and will aim to increase access to evidence based preventive practices that maintain optimal health for all ages.

Water Fluoridation

Healthy People 2010-Oral Health proposes to increase the proportion of the U.S. population served by community water systems with optimally fluoridated water in order to reduce dental caries. As noted in *Oral Health in America: A Report of the Surgeon General*, community water fluoridation continues to be the most cost-effective, equitable, and safe means to provide protection from tooth decay in a community.

In Michigan, 73% of the state's population is served by a community water system. Of the individuals served by community water, 89.4% are being provided with adequately fluoridated water. This equates to 65.3% of Michigan residents who are being served by a community water supply with adequately fluoridated water (MDEQ 2003). Nationally, 67% of the population served by public water supplies is provided with optimal fluoride levels for preventing decay (CDC, 2004).

Figure 4.

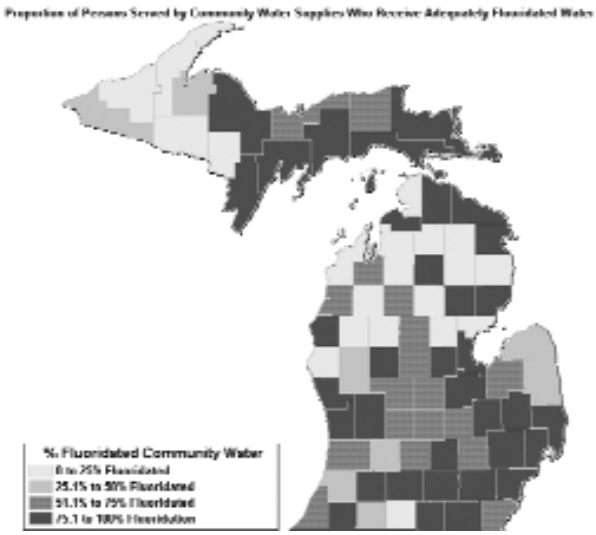


Figure 4 shows the proportion of persons served by community water supplies who receive adequate fluoridation levels by county. Fluoride levels in Michigan will continue to be monitored and reported by the Michigan Department of Environmental Quality and, through coordination with the MDCH, Oral Health Program, the Water Fluoridation Reporting System (WFRS) will be encouraged. This system monitors the extent and consistency of water fluoridation.

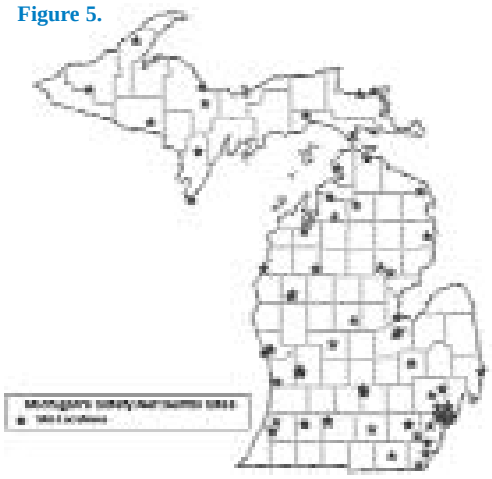
School-Based or School-Linked Sealant Programs

The Michigan Oral Health Coalition recognizes that sealants are an effective method to prevent tooth decay. The coalition supports efforts by the Michigan Department of Community Health to implement a school-based and school-linked sealant program in conjunction with coalition partners, including the School Community Health Alliance of Michigan.

Publicly Supported Dental Clinics

Michigan currently has 75 community based, publicly supported dental clinics. The number of clinics grew in Fiscal Year 2000 when the legislature appropriated $10.9 million for a one-time oral health expansion grant. This grant allowed for the uninsured and Medicaid beneficiaries in many communities to access oral health services that had been desperately needed. However, with the elimination of the adult oral health benefits for Medicaid enrollees in 2003, and the increased number of persons without dental insurance, the infrastructure developed in 2000 is in jeopardy. Clinics are reducing hours eliminating services, and laying off dedicated staff. Some clinics have recently been forced to close.

Figure 5.



The map to the left (Figure 5) shows each of the publicly supported dental sites in Michigan today. The services provided at each site vary from cleanings to restorations. Some provide services to only children or adults, while others provide a full-range of oral health services to the community.

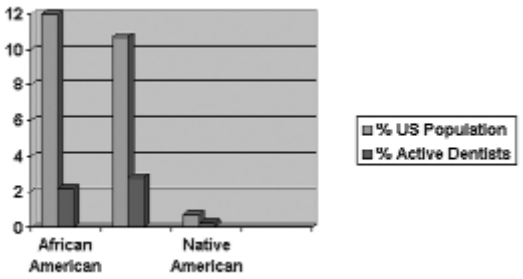
Dental Providers

According to 2004 MDCH dental licensing information, Michigan has 6,366 licensed dentists for an overall population to dentist ratio of 1,561 to 1 (MDCH Licensing, 2004). The overall population to dentist ratio is based on dentists licensed to practice in Michigan and is not adjusted for those who are not currently practicing in the state or who are working part-time.

There is a shortage of providers willing to serve low-income populations. According to the Michigan Department of Community Health, 8% of Michigan counties (7 out of 83 counties) have no enrolled Medicaid dentists (MDCH CDC, 2004). According to the same report, only 43% (36 out of 83) of the counties have only one enrolled Medicaid dentist with paid claims above $10,000 per year. Sixty-five out of 83 Michigan counties are designated as a full or partial Health Professional Shortage Area (HPSA) for low income and Medicaid populations. A map showing the Dental Health Professional Shortage Areas (HPSAs) by county can be found below (HHS 2004).

Figure 6.

Figure 7.



Nationally, specific racial and ethnic groups are underrepresented in dentistry compared to their representation in the population. According to the document, *A National Call to Action to Promote Oral Health*, African Americans comprise 2.2% of active dentists versus 12% of the population; Hispanics comprise 2.8% of active dentists versus 10.7% of the population; Native Americans comprise 0.2% of active dentists versus 0.7% of the population (HHS, 2003). We believe a similar disparity exists in Michigan. The Workforce Workgroup is interested in exploring this further.

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Summary of Recommendations

Data Workgroup

- Develop a statewide oral health surveillance system to provide a routine source of actionable data.
- Increase the sustainability of the statewide oral health surveillance system.
- Provide assistance in the collection and analysis of oral health data related to major policy changes and prevention and intervention initiatives.

Prevention, Education & Awareness Workgroup

- Increase access to evidence-based prevention practices that maintain optimal health.
- Develop a statewide education program aimed at increasing knowledge about the relationship between oral health and systemic health.
- Assure the availability of comprehensive, culturally competent, oral health education resources for all ages as well as those designed to enhance patient involvement through self management.
- Increase the education of non-dental health care providers on the importance of oral health.
- Encourage health care providers to discuss with patients the oral effects of tobacco use (cigarettes, cigars, pipes, and spit tobacco).

Funding Workgroup

- Create a Medicaid adult oral health benefit that ensures access to and is consistent with high quality of care standards.
- Support efforts to roll out Healthy Kids Dental as the preferred model for optimal oral health care in children with the gradual expansion to additional counties based on those counties with greatest need and funding availability.
- Develop a system of care that ensures access to oral health services for low-income uninsured populations.
- Support efforts of the other coalition work groups to assess resources needed to implement their initiatives.
- Ensure the successful implementation of the oral health plan through the acquisition of needed resources.

Workforce Workgroup

- Increase access to oral health services in medically underserved communities and for medically underserved populations by allowing the provision of high-quality dental care through qualified health care providers.
- Develop and support incentive programs to attract oral health professionals to underserved areas and to serve medically underserved populations.
- Create and maintain a process for assessing and responding to the supply of and demand for oral health professionals.
- Develop a dental director leadership position in state government or at the Michigan Department of Community Health to serve as the focal point of oral health activity for the state.
- Facilitate provider education and medical care facility access to improve oral health care for persons with special needs.

Action Plan Matrix for the Oral Health Plan of Action

DATA WORKGROUP

A **Recommendation/Strategy:** Develop a statewide oral health surveillance system to provide a routine source of actionable data.

Rationale: Routine surveillance will allow us to:

1) estimate the magnitude of oral health disease in Michigan
2) monitor trends in oral health indicators
3) evaluate the effectiveness of implemented programs and policy changes
4) identify vulnerable population groups
5) provide information for decision-making when allocating resources

Action Step	Resources/ Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism/ Evaluation	Completion Date(s)/ Frequency
1 Explore options to measure the proportion of children and adolescents who have dental caries in their primary or permanent teeth through the use of open mouth screenings.	These screenings would require volunteer dental staff and participation from schools, parent-teacher organizations, and parents. The Basic Screening Survey (BSS) would be a useful to or for this screening.	The Data Workgroup	Consistency of caries measurement by dental providers would need to be standardized using a recommended calibration system.	Surveillance through open mouth screenings could begin September 2005. Frequency is yet to be determined.
2 Measure the proportion of children and adolescents with untreated dental decay by exploring the use of open mouth screenings.	These screenings would require volunteer dental staff and participation from schools, parent-teacher organizations, and parents. The Basic Screening Survey (BSS) would be a useful to or for this screening.	The Data Workgroup	Consistency of caries measurement by dental providers would need to be standardized using a recommended calibration system.	Open mouth screenings could begin September 2005. Frequency is yet to be determined.

Data Workgroup Recommendation A continued on page 18

Data Workgroup Recommendation A continued

Action Step	Resources/ Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism/ Evaluation	Completion Date(s)/ Frequency
3 Measure the proportion of adults who have never had a permanent tooth extracted because of dental caries or periodontal disease.	Behavioral Risk Factor Surveillance System (BRFSS)	BRFSS Coordinator	BRFSS Response Rates	Annual
4 Measure the proportion of older adults who have had all their natural teeth extracted.	BRFSS	BRFSS Coordinator	BRFSS Response Rates	Annual
5 Investigate options to measure the prevalence of periodontal disease.	National Health and Nutrition Examination Survey (NHANES). The use of self assessment questions as methodology is currently being examined by a CDC workgroup.	The Data Workgroup	NHANES Response Rates	As conducted
6 Measure the proportion of oral and pharyngeal cancers detected at the earliest stage.	The State Cancer Registry and the Detroit Cancer Registry.	Collaboration with the cancer registries	Internal data quality assurance through the registry	Annual
7 Explore options to measure the proportion of adults who, in the past 12 months, report having had an examination to detect oral and pharyngeal cancers.	The BRFSS could be used to obtain patient oriented results or a DDS survey could obtain information from providers.	The Data Workgroup		As conducted
8 Measure the proportion of children who have received dental sealants on their molar teeth through the use of open mouth screenings.	The Basic Screening Survey (BSS) is an open mouth screening. These screenings would require volunteer dental staff and participation from schools, parent-teacher organizations, and parents.	The Data Workgroup	Consistency among dental providers would need to be measured using a recommended calibration system.	Open mouth screenings could begin September 2005. Frequency is yet to be determined.

Data Workgroup Recommendation A continued on page 19

Data Workgroup Recommendation A continued

Action Step	Resources/ Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism/ Evaluation	Completion Date(s)/ Frequency
9 Measure the proportion of the Michigan population served by community water systems with optimally fluoridated water.	The Michigan Department of Environmental Quality (DEQ) can provide information on community water supplies, including those artificially fluoridated, and the Environmental Protection Agency (EPA) provides information on naturally fluoridated community water supplies.	DEQ and EPA	Internal monitoring mechanisms	Annual
10 Measure the proportion of children and adults who use the oral health care system each year through review of claims data.	Claims data from private insurers and Medicaid. Adult information can be through the BRFSS for adults. Care provided to the uninsured through safety net dental programs will also be examined.	The Data Workgroup and the BRFSS Coordinator		Annual
11 Measure the proportion of long-term care residents who use the oral health care system each year.	Minimum Data Set for Home Care Survey. The workgroup might also examine additional resources to identify oral disease among long-term care residents, as the MDS is not an accurate tool for this assessment.	Collaboration between the Community and Home-Based Waiver Program and the Data Workgroup	This survey has been previously validated as a measurement for use of the oral health care system	Annual
12 Measure the proportion of low-income children and adolescents who received any preventive dental service during the past year.	Medicaid claims data	MDCH		Annual
13 Measure the proportion of school-based health centers with an oral health component.	Survey of school-based health centers	School Health Alliance		As conducted (every 2 years)

Data Workgroup Recommendation A continued on page 20

Data Workgroup Recommendation A continued

Action Step	Resources/ Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism/ Evaluation	Completion Date(s)/ Frequency
14 Measure the proportion of local health departments and community-based health centers, including community, migrant, and homeless health centers, that have an oral health component.	The Oral Health Program Directory	MDCH, MPCA	Updated annually	Annual
15 Measure the quality of the system for recording and referring infants and children with cleft lips, cleft palates, and other craniofacial anomalies to craniofacial anomaly rehabilitative teams.	The Birth Defects Registry	The Birth Defects Registry	Internal through the Birth Defects Registry	Annual
16 Develop an oral and craniofacial health surveillance system.	All oral health data resources available in the state	The Data Workgroup	Ongoing	Annual
17 Measure the number of tribal, state (including the District of Columbia), and local health agencies that serve jurisdictions of 250,000 or more persons that have in place an effective public dental health program directed by a dental professional with public health training.	The Oral Health Program Directory	MDCH	Updated annually	Annual
18 Assess the distribution and diversity of the oral health workforce.	*Current:* MDCH, Bureau of Health Professions *Future:* Licensing Survey for Dentists & Hygienists	MDCH, Bureau of Health Professions	Participation rate	Annual

B **Recommendation/Strategy:** Increase the sustainability of the statewide oral health surveillance system.

Rationale: A surveillance system should be feasible, adaptable, representative, and acceptable. A passive surveillance system should work towards minimizing resource costs while maximizing data quality and stability yet remain adaptable to changing needs.

Action Step	Resources/ Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism/ Evaluation	Completion Date(s)/ Frequency
1 Enlist the cooperation of dental insurance providers in obtaining information regarding utilization of dental services.	Dental insurance providers, MDCH	MDCH	Participation by insurers and quality of information provided	November 2005
2 Explore integration of technological alternatives to oral health screenings for future statewide surveillance measures (e.g. the use of Electronic Medical Records).	Data Workgroup	Data Workgroup	Methodology is developed for major policy changes and/or statewide initiatives	Ongoing

C **Recommendation/Strategy:** Provide assistance in the collection and analysis of oral health data related to major policy changes and prevention and intervention initiatives.

Rationale: Policy changes related to oral health can have both positive and negative implications for the oral health status of Michigan residents. Measuring the effect of these changes is necessary in order to develop sound oral health policy. The impact of these changes cannot always be identified by the proposed surveillance system.

Action Step	Resources/ Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism/ Evaluation	Completion Date(s)/ Frequency
1 Coordinate with the MDCH Oral Health Program Coordinator to monitor policy changes and new prevention and intervention initiatives.	MDCH Oral Health Program Coordinator	MDCH Oral Health Epidemiologist	Policy changes and initiatives are brought to the Data Workgroup for discussion.	Ongoing

Data Workgroup Recommendation C continued on page 22

Data Workgroup Recommendation C continued

Action Step	Resources/ Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism/ Evaluation	Completion Date(s)/ Frequency
2 Collect and analyze information related to the changes.	Varied by intervention/policy change. The MDCH Data Warehouse.	Data Workgroup	Analysis is completed for major policy changes and/or statewide initiatives	Ongoing

PREVENTION, EDUCATION, & AWARENESS WORKGROUP

A **Recommendation/Strategy:** Increase access to evidence-based preventive practices that maintain optimal oral health.

Rationale: There are a number of safe, evidence-based methods to prevent dental caries, including nutrition education, sealants, water fluoridation, and fluoride varnishes.

Action Step	Resources/ Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism/ Evaluation	Completion Date(s)/ Frequency
1 Support communities in efforts to maintain and implement optimal levels of water fluoridation.	MDA, DEQ, MDCH	MDCH	Percent of communities with optimally fluoridated water is maintained or increased	Ongoing
2 Support efforts by MDCH to implement a school rinse program in non-fluoridated communities.	Funding, coordinator	MDCH Oral Health Lead	School rinse program is implemented	Ongoing
3 Support efforts by MDCH to implement a school-based school-linked sealant program.	Funding, coordinator, equipment, local health departments, and school-based health centers	MDCH Oral Health Lead	School-based school-linked sealant program is implemented	June 2007
4 Support efforts by MDCH to implement the application of fluoride varnishes during the well child visits.	Ensure this is allowable under the scope of practice for physicians and nurses and check with insurance companies to insure that they will accept dental codes from medical providers.	MDCH	Fluoride varnishes are incorporated into well child visits according to annual query of insurance claims by MDCH	June 2006

Prevention, Education, & Awareness Workgroup Recommendation A continued on page 23

Prevention, Education, & Awareness Workgroup Recommendation A continued

Action Step	Resources/ Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism/ Evaluation	Completion Date(s)/ Frequency
5 Evaluate the effectiveness for improving oral health by mandating an oral health exam prior to entrance into kindergarten.	Research on other areas that this has been done for and its effectiveness	Delta Dental, MDCH	Study of effectiveness is completed	August 2007
6 Explore preventive practices for prenatal and postpartum oral health care.	Research of best practices	MDCH Oral Health Program Coordinator	Research completed and recommendations made to the coalition	June 2007
7 Provide training on the CDC's Guidelines for Infection Control in Dental Health Settings.	The CDC guidelines as a model, the oral health conference as a training venue	MDCH Oral Health Program Coordinator	Training provided	June 2007

B

Recommendation/Strategy: Develop a statewide education program aimed at increasing knowledge about the relationship between oral health and systemic health.

Rationale: Oral health is essential to systemic health. When developing health policy, oral health must be considered primary care.

Action Step	Resources/ Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism/ Evaluation	Completion Date(s)/ Frequency
1 Coordinate a statewide public education and awareness campaign.	MDCH, Delta Dental, Blue Cross Blue Shield, private industry partners, local broadcasting and other media	MDCH Oral Health Program Coordinator and partnership with insurers and private industry	Public relations plan and campaign developed	CY 2005 and then annually

Prevention, Education, & Awareness Workgroup Recommendation B continued on page 24

Prevention, Education, & Awareness Workgroup Recommendation B continued

Action Step	Resources/ Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism/ Evaluation	Completion Date(s)/ Frequency
2 Continue to build networks throughout the state to improve education on the importance of oral health for individuals of all socioeconomic levels and special populations throughout the lifespan, particularly for the elderly.	Partners: Michigan State Medical Society (MSMS), Michigan Osteopathic Association (MOA), Michigan Association of Health Plans (MAHP), MPCA, Michigan Dental Association (MDA), Michigan Dental Assistants Association (MDAA), Michigan Dental Hygiene Association (MDHA), MDCH, Michigan Resource Center (MRC), cancer societies, diabetes associations, dietitians, Maternal Support Services/ Infant Support Services (MSS/ISS) groups, Michigan Department of Education (DOE), Delta Dental, Blue Cross Blue Shield (BCBS), Michigan Action for Healthy Kids (MAHK), Michigan Model Coordinators, The School Community Health Alliance, etc.	Oral Health Coalition and partners	Networking continues	CY2004 and then ongoing
3 Coordinate a statewide oral health observance for the month of February.	MDA, MDHA, MPCA, dental hygiene programs, and other dental societies as well as educational institutions for materials.	Delta Dental, BCBS, MDA, MDHA, MDAA, and others for funding.	Michigan Dental Association annual observance is coordinated	CY 2005 and then annually (every February)
4 Partner with the Michigan Surgeon General to promote oral health.	MDCH Surgeon General's office	Coalition	Oral health recognition in documents released by Surgeon General's office	CY 2005 and then annually

C Recommendation/Strategy: Assure the availability of comprehensive, culturally competent, oral health education resources for all ages as well as those designed to enhance patient involvement through self management.

Rationale: In order to increase awareness about the importance of oral health, age appropriate information should be provided to health professionals, parents, teachers, etc.

Action Step	Resources/ Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism/ Evaluation	Completion Date(s)/ Frequency
1 Partner with Head Start agencies in their project to ensure oral health education and prevention activities are available.	Curricula development, staff coordination	Michigan Head Start Association	Materials are available	December 2005
2 Identify existing health resource clearinghouses for dissemination of electronic information and written materials, particularly for oral health. (e.g., the Prevention Resource Center).		Coalition	Existing resources identified	September 2005
3 Identify funding for a clearing-house of oral health materials that would direct people to appropriate resources.	Funding for staffing and technology, distribution of materials, etc.	Coalition	Funding is obtained	March 2006
4 Establish the clearinghouse for oral health.	Funding for staffing and technology, distribution of materials, etc.	Coalition	The clearinghouse is established	September 2006
5 Provide information on the availability of the clearinghouse as a resource to health providers, educators, etc.	Brochures, web links to other commonly visited websites	MPCA, MDCH, The Michigan Education Association (MEA), Michigan's Surgeon General, Oral Health Coalition members	Increase in the use of the clearinghouse	September 2006 and ongoing

Prevention, Education, & Awareness Workgroup Recommendation C continued on page 26

Prevention, Education, & Awareness Workgroup Recommendation C continued

Action Step	Resources/ Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism/ Evaluation	Completion Date(s)/ Frequency
6 Work with the Department of Education to continue oral health modules in school curriculum.	The Michigan Model	Department of Education, MDCH, and Education & Awareness Workgroup	Oral health modules are continued	Ongoing
7 Provide a self management curriculum focused on oral health to Women, Infant and Children (WIC) providers; Maternal Support Services/Infant Support Services (MSS/ISS) providers; Children's Special Health Care Services (CSHCS); School-based health centers; after school day care centers; and summer care programs.		Department of Education and MDCH	Curriculum is provided	Ongoing

D **Recommendation/Strategy:** Increase the education of non-dental health care providers on the importance of oral health.

Rationale: To optimize patient care by assuring that oral health is an integral component of primary care.

Action Step	Resources/ Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism/ Evaluation	Completion Date(s)/ Frequency
1 Ensure that annual trainings/ continuing education opportunities are available annually for all health care providers on topics such as the following: -the relationship between oral health and maternal health; -the role that oral health can play with chronic diseases, such as diabetes; -the oral side effects of many medications; -the role of tobacco in oral health and screening; -screening and referral for early signs of decay in infants/children; -the relationship between oral health and systemic health; and -optimizing oral health in medically-compromised populations.	Staff, funding. Make available speakers for health professional conferences such as those hosted by the American College of Obstetrics and Gynecology (ACOG), American Academy of Pediatrics (AAP), Michigan Association of Family Practice (MAFP), American Association of Retired People (AARP), Society of Pubic Health Educators (SOPHE), MSMS, MOA, Michigan Nurses Association (MNA), MDCH, MPCA, MDA, Delta Dental, Blue Cross Blue Shield, etc. Online continuing education. Website links on MPCA, MDA, MDCH, etc.	MPCA, MDCH	Trainings on the listed topics will be available annually and a list of trainings will be widely distributed across the state	June 2005 and annually
2 Ensure that medical school and nursing school curricula include information on the interplay between oral health and physical health, as well as information on empowering self management in patients.	Staff time, deans of medical schools	MDCH, MPCA	Information is included in the curricula	September 2008

E Recommendation/Strategy: Encourage health care providers to discuss with patients the oral effects of tobacco use (cigarettes, cigars, pipes, and spit tobacco).

Rationale: There is a direct link between tobacco use and oral health.

Action Step	Resources/ Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism/ Evaluation	Completion Date(s)/ Frequency
1 Measure and improve the level of oral cancer knowledge in medical education.	Survey of medical schools and oral cancer curricula	MDCH Oral Health Epidemiologist	Survey completed	June 2006
2 Incorporate tobacco prevention and cessation training in health education program curriculum (dental, dental hygiene, dental assisting, nursing, and other medical education programs).	Support of faculty and deans of schools	MDCH oral health leader	Information is included annually in curriculum	September 2008
3 Increase oral cancer screenings by all health care providers, including dentists and dental hygienists.	CEU courses	Oral Health Coalition	Annual data collected by MDCH will indicate an increase in oral cancer screenings. QHP Annual Report and Delta Dental data can also be utilized.	Ongoing
4 Encourage participation by dental professionals in state and local tobacco coalitions.		MDA, MDHA, Tobacco Free Michigan (TFM), and Oral Health Coalition Partners.	Increased participation by dental professionals	Ongoing
5 Explore grant opportunities for tobacco prevention, cessation, and control activities.	Federal and foundation funding, Michigan Association of Health Plans (Taking on Tobacco).	Michigan Spit Tobacco Education Program Coordinator and the MDCH Tobacco Prevention Program.	Funding for tobacco related activities is obtained	Ongoing

FUNDING WORKGROUP

A **Recommendation/Strategy:** Create a Medicaid adult oral health benefit that ensures access to and is consistent with high quality of care standards.

Rationale: Research has shown that poor oral health has a tremendous impact on an individual's overall health. Poor oral health has been linked to health problems such as pre-term births, uncontrolled diabetes, and heart disease. The elimination of the adult dental benefit will result in increased Medicaid medical costs since the services sought by individuals unable to get appropriate dental services are still covered by the Medicaid program.

Action Step	Resources/ Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism/ Evaluation	Completion Date(s)/ Frequency
1 Reinstate a Medicaid adult dental benefit.	$10 million in general fund dollars	MDCH, Coalition	Benefit is reinstated	Fiscal Year 2007
2 Implement an effective and efficient adult Medicaid dental benefit that provides meaningful access by increasing provider reimbursement and encouraging provider participation.	Will be determined based on plans	MDCH, MDA, MALPH, MPCA, Coalition	*Primary:* Utilization, provider participation *Secondary:* Bi-annual review of payment rates compared to UCR	Phase-in completed by Fiscal Year 2009
3 Encourage MDCH to provide the local match required for local health departments to access Title V dollars.	$1.2 million	Dental Clinics North, MALPH	State funds provided for local match	Fiscal Year 2006
4 Work with the MDCH to modify the Medicaid oral health benefits to reflect the current standards of practice.	Staff time	Michigan Dental Association	Benefit reflects current standards of practice	Fiscal Year 2007
5 Support efforts to mandate oral health as part of the Medicaid package.	Commitment and staff time	MPCA will work with NACHC and the ASTDD; MDA will work with ADA; MDHA will work with the ADHA	Dental services are a mandatory benefit for Medicaid	Fiscal Year 2007

B **Recommendation/Strategy:** Support efforts to roll out *Healthy Kids Dental* as the preferred model for optimal oral health in children with the gradual expansion to additional counties based on those counties with greatest need and funding availability.

Rationale: Research has shown that poor oral health has a tremendous impact on an individual's overall health. Michigan must commit itself to giving our children the best possible start at a healthy life.

Action Step	Resources/ Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism/ Evaluation	Completion Date(s)/ Frequency
1 Support efforts to roll out *Healthy Kids Dental* as the preferred model and explore strategies to expand.	Staff time	Oral Health Coalition	Common strategy is formed by partners	As funding becomes available

C **Recommendation/Strategy:** Develop a system of care that ensures access to oral health services for low-income uninsured populations.

Rationale: Research has shown that poor oral health has a tremendous impact on an individual's overall health.

Action Step	Resources/ Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism/ Evaluation	Completion Date(s)/ Frequency
1 Inventory existing programs and resources in Michigan.	Staff time	Coalition	Inventory created	December 2005
2 Research and inventory models that work across the country.	Staff time	Coalition	Inventory created	January 2006
3 Look at employer incentives to provide dental coverage.	Staff time	Coalition	Summary of options available	February 2006
4 Determine best possible strategy(s) for Michigan to increase access to oral health services.	Meeting of partnership and facilitated discussion	Coalition	Common strategy is formed by partners	March 2006
5 Identify any legislative or administrative changes necessary to implement strategy.	Staff time	MDCH	Potential challenges identified	April 2006

Funding Workgroup Recommendation C continued on page 31

Funding Workgroup Recommendation C continued

Action Step	Resources/ Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism/ Evaluation	Completion Date(s)/ Frequency
6 Implementation plan developed to overcome challenges identified in Action Step 3.	Meeting of partnership and facilitated discussion	MDA, MPCA	Plan created	May 2006
7 Implementation plan initiated.	Dependent on plan	Each partner organization	Activities in plan completed	Initiated immediately with completion dependent on plan and availability of funding

D

Recommendation/Strategy: Support efforts of the other coalition workgroups to assess resources needed to implement their initiatives.

Rationale: To maximize the coalition's efforts to implement initiatives proposed as part of the Plan of Action

Action Step	Resources/ Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism/ Evaluation	Completion Date(s)/ Frequency
1 Support efforts of the other coalition workgroups to assess resources needed to implement their initiatives.	Staff time	Determined by initiative under study	Workgroup recommendations are accompanied by resource needed estimates	Determined by initiative under study

E

Recommendation/Strategy: Ensure the successful implementation of the Oral Health Plan through the acquisition of needed resources.

Rationale: In order to successfully complete many of the initiatives listed in the Plan of Action, the Coalition will need to pursue additional financial resources.

Action Step	Resources/ Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism/ Evaluation	Completion Date(s)/ Frequency
1 Pursue funding sources to support recommendations A, B &C and those of the other Work Groups.	Partner meetings, staff time	Coalition	Plan is implemented with annual progress review	Ongoing with completion September 2010

WORKFORCE WORKGROUP

A **Recommendation/Strategy:** Increase access to oral health services in medically underserved communities and for underserved populations by allowing the provision of high quality dental care through qualified health care providers.

Rationale: There is a serious shortage of dentists willing to care for the uninsured and publicly insured populations. In addition, a number of communities lack enough dentists to care for even the commercially insured population. This strategy will allow us to increase the number of people who receive regular, high quality oral health care from qualified professionals.

Action Step	Resources/ Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism/ Evaluation	Completion Date(s)/ Frequency
1 Inquire with potential partners to identify willingness to participate.	Staff time	Coalition	Partnership formed	Ongoing
2 Research approaches used by other states to address access issues with current workforce.	Staff time	Coalition	Assessment completed	September 2006
3 Develop a plan to address issues identified in survey completed by Data Workgroup.	MDA, MDHA, MDAA, MPCA	Coalition	Plan is developed	July 2007
4 Identify any legislative or administrative changes necessary to implement strategy.	Staff time	Coalition	Potential challenges identified	July 2007
5 Implement plan.	MDA, MDHA, MDAA, MPCA	Coalition	Plan implemented, annual review	July 2008
6 Periodic evaluation of progress and modification of strategies and/or implementation plan made as appropriate.	MDA, MDHA, MDAA, MPCA	Coalition	Quarterly meetings of the partnership	Ongoing

B **Recommendation/Strategy:** Develop and support incentive programs to attract oral health care professionals to underserved areas and to serve the medically underserved populations.

Rationale: There is a serious shortage of dentists willing to care for the uninsured and publicly insured populations. In addition, a number of communities lack the dentists to care for even the commercially insured population. This strategy will allow us to increase the number of people who receive regular, high quality oral health care from qualified professionals.

Action Step	Resources/ Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism/ Evaluation	Completion Date(s)/ Frequency
1 Inventory existing state and federal incentive programs and include benefits/ limitations and impact information.	Staff time	Coalition	Inventory created	August 2006
2 Research approaches used by other states to address access issues with incentive programs.	Staff time	MPCA	Summary of creative approaches	October 2006
3 Determination of best possible strategy(s) for Michigan.	Meeting of workgroup and facilitated discussion	Coalition	Common strategy is identified	November 2006
4 Identify and support legislative or administrative changes necessary to implement changes to existing programs or create new ones.	Staff time	Coalition	Potential challenges identified	January 2006
5 Implement plan.	MDA, MDHA, MDAA, MPCA	Coalition	Plan created	March 2007
6 Periodic evaluation of progress and modification of strategies and/or implementation plan made as appropriate.	Meeting of partnership and facilitated discussion	MPCA	Quarterly meetings of the partnership	Ongoing

C Recommendation/Strategy: Create and maintain a process for assessing and responding to the supply of and demand for oral health professionals.

Rationale: Very little quantifiable information is gathered and analyzed on the amount of oral health resources currently available. Until we can determine what we already have, it will be difficult to gather enough momentum to change the system to better meet our needs.

Action Step	Resources/ Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism/ Evaluation	Completion Date(s)/ Frequency
1 Inventory other states' approaches for monitoring workforce supply and/or demand.	Staff time	Michigan Health Council	Inventory created	July 2006
2 Estimate resources required to implement most promising processes identified in Action Step 1.	Staff time	MDCH, Michigan Health Council	Resources estimated for most promising processes	August 2006
3 Determination of best possible process(s) for Michigan.	Meeting of work group and facilitated discussion	Coalition	Best process for Michigan is identified	September 2006
4 Identify any legislative or administrative changes necessary to implement identified strategy.	Staff time	Coalition	Potential challenges identified	November 2006
5 Develop plan.	Staff time	MDCH	Plan created	March 2007
6 Implement plan.	Dependent on plan	Each partner organization	Activities in plan completed	Annually

D **Recommendation/Strategy:** Develop a dental director leadership position in state government or at the Michigan Department of Community Health to serve as the focal point of oral health activity for the state.

Rationale: There is a lack of leadership in oral health within the State of Michigan administration that can effectively work with all components of the health care system and professional training programs.

Action Step	Resources/ Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism/ Evaluation	Completion Date(s)/ Frequency
1 Initiate conversations with MDCH administration regarding coalition's support for a dental director.	Staff time	Michigan Public Health Association - Oral Health Section	Conversations began	January 2006
2 Develop the coalition's qualifications for the dental director position.	Staff time	Michigan Public Health Association - Oral Health Section	Wish list created	January 2006
3 Support a dental director leadership position in state government which has the power and authority for policy development and implementation.	Meetings	MPHA, MDA, Coalition	Position established and filled with qualified candidate	October 2007

E Recommendation/Strategy: Facilitate provider education and medical care facility access to improve oral health care for persons with special needs.

Rationale: Medically compromised and mentally impaired individuals often need sedation that requires a medical facility or hospital setting for dental care delivery. The state's current programs cannot adequately address access both in terms of wait time and travel time. For those patients who can receive care in an ambulatory setting, there is a shortage of providers who feel they have the training and who are comfortable with special needs patients in their practices. Curriculum in the dental schools includes only minimal training and clinical experience with special needs patients for general dentists resulting in their thinking only specialists can treat them.

Action Step	Resources/ Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism/ Evaluation	Completion Date(s)/ Frequency
1 Explore the need for additional hospital dentistry programs in the state.	**a)** Assessment of hospital programs, including radiation oncology centers **b)** Assessment of dentists regarding their current hospital involvement and experience **c)** Assess oral health access for developmentally disabled population	**a)** Data workgroup partnering with universities **b)** Data workgroup partnering with universities **c)** Data workgroup and MDCH	Assessment completed	December 2006
2 Conduct meetings with key state groups to get their input and their support for the program.	MDA, MDHA, MHA, Michigan State Medical Society, Schools of Dentistry, Schools of Dental Hygiene	Workforce Workgroup	Documentation of meetings	Ongoing
3 Foster relationships between local dental groups and their community hospital and other medical facilities.	Schools of Dentistry, Schools of Dental Hygiene	Workforce Workgroup, Schools of Dentistry	Documentation of meetings	Ongoing
4 Provide training to dentists on practicing in a hospital/medical facility setting.	Residency programs, continuing education programs	Schools of Dentistry	Documentation of trainings	Annual

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Workforce Workgroup Recommendation E continued

Action Step	Resources/ Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism/ Evaluation	Completion Date(s)/ Frequency
5 Provide information to dentists in areas of hospital protocol, credentialing, billing medically-related care, etc. that will encourage their involvement.	**a)** Residency programs, continuing education programs **b)** Handbook to provide information to others on how it's done	Schools of Dentistry	Documentation of training material development and distribution	Ongoing
6 Provide training and education programs for dental hygienists and dental assistants practicing in public health and hospital/medical facility settings.	Continuing education, curriculum development, off-campus placement	Schools of Dental Hygiene and Dental Assisting Training Programs	Documentation of trainings	Annual
7 Seek financial and legislative support for the development of additional geographically diverse medical facilities.	Meetings with MDA, MHA, Michigan State Medical Society, and Schools of Dentistry; staff time	Schools of Dentistry	Documentation of meetings	December 2006
8 Provide training to providers on treating special needs patients in an ambulatory setting through online courses and other continuing education.	Staff time	Schools of Dentistry, MDA, Schools of Dental Hygiene	Documentation of materials and trainings completed	December 2006
9 Identify network of providers who will accept special needs patients in their practice.	Meetings with MDA to discuss survey development and implementation. Staff time.	Workforce Workgroup, Schools of Dentistry, Schools of Dental Hygiene	Development of the network	December 2007
10 Meet with the Schools of Dentistry to discuss changes in the curriculum and increased clinical experience for dental students to improve their aptitude for treating special needs patients.	Staff time	Workforce Workgroup	Documentation of meetings	December 2006